STATE OF VERMONT EMPLOYEE MEDICAL PLAN OPTIONS FOR OVER 65 RETIREES
Effective January 1, 2011

Benefit/Feature	TotalChoice Plan	HealthGuard PPO Plan	
		In-network	Out-of-Network
Annual DEDUCTIBLE	$300 per person; $600 per family	$300 per person; $600 per family	$500 per person; $1,000 per family
MAXIMUM annual COPAYS (after deductible is met)	$750 per person; $2,250 per family	$2,000 per person; $6,000 per family	$4,000 per person; $12,000 per family
Maximum Lifetime Benefit Per Member	None	None	None
PERCENTAGE THAT THE PLAN PAYS			
Inpatient Hospital	90%	80%	60%
Outpatient Hospital	80%	80%	60%
Emergency Room	80%	80%	60%
Physician Charges			
• **Office visit**	80%	80%	60%
• **Surgery**	90% inpatient; 80% outpatient	80%	60%
• **In-Hospital visit**	90%	80%	60%
Diagnostic X-ray and Labs	80%	80%	60%
Home Healthcare	80%	80%	60%
COMMON BENEFITS IN ALL PLAN OPTIONS			
Preventive Exams & Tests-Program Benefits	1. Physicals (includes well child care). 2. Immunizations 3. Prostate & GYN exams. 4. Mammograms. Included as regular benefits subject to the plan coinsurance, or copay, if applicable. However, maximum out-of-pocket expense of $25 applies. 5. Colonoscopies. Included as regular benefis subject to the plan coinsurance, or copay, if applicable. However, maximum out-of-pocket expense of $100 applies. Benefit provided to all members, including dependents.		
Wellness Program Benefits	Available to all active employees and retirees in any of the health plan options, at no charge to the employee or retiree		
Mental Health & Sustance Abuse Program Benefits	In-Network: Paid at 100%. No predetermined visit or day limits. Out-of- Network: Visit & day limits apply. Deductibles & copay required.		
Prescription Drugs • **Retail** • **Mail**	This is a prescription drug card plan, which combines both local retail and mail order drugs. There is an annual $25 per person/$75 family deductible. Individual pays 10% copay for generic drugs, 20% copay for preferred brand drugs, and 40% copay for non-preferred brand drugs. 40% copay drugs will **not** be counted toward the maximum out-of-pocket limit, except for Speciality drugs. Maximum out-of-pocket is $775 per covered member per year for both retail and mail order, **including** the deductible.		
Routine Vision Care	The plan pays $100 every two years, with no deductible and coinsurance, or copay. Benefits available for every plan member, **including dependents.** Covers routine exams and/or lens changes.		